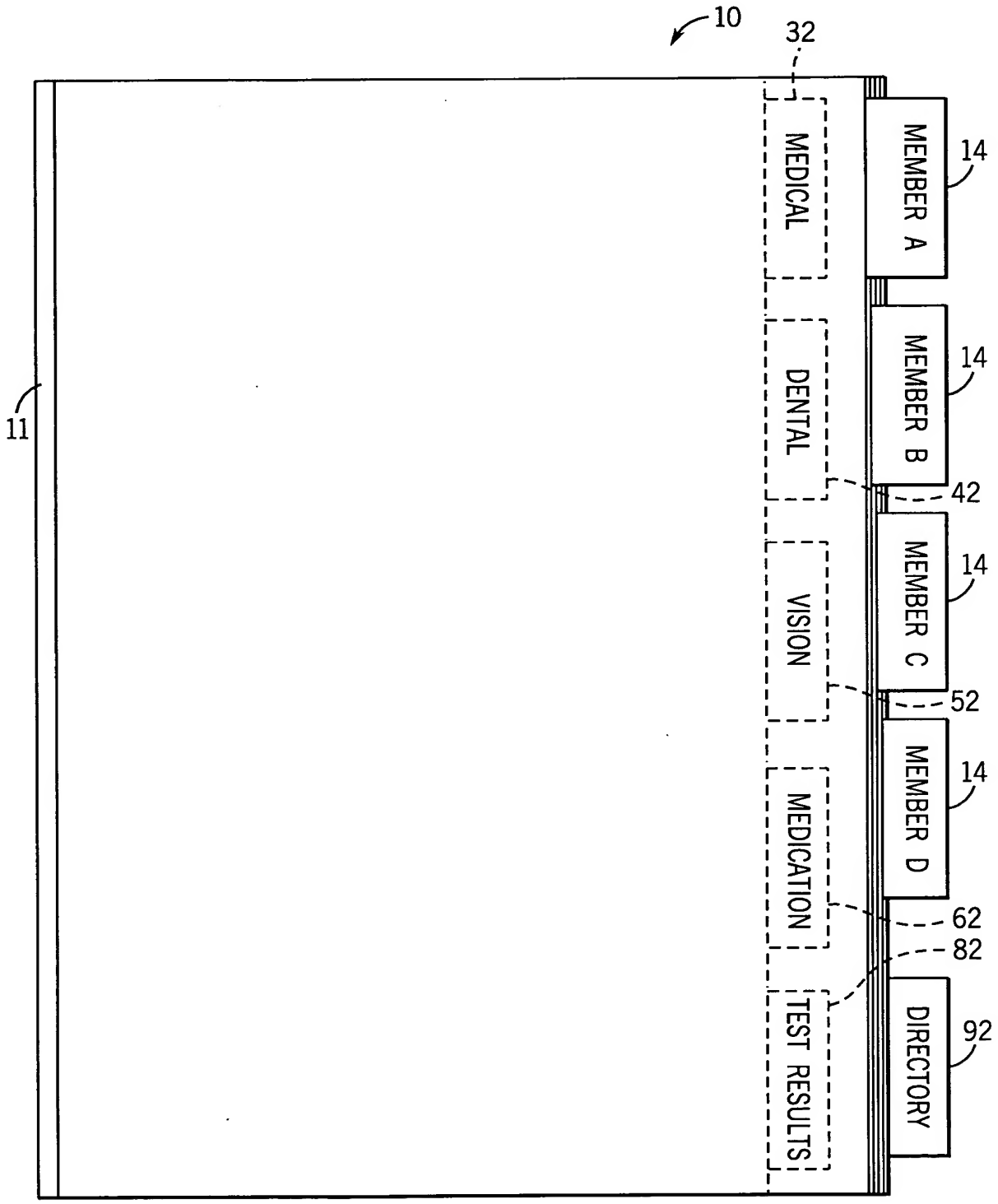

FIG. 1

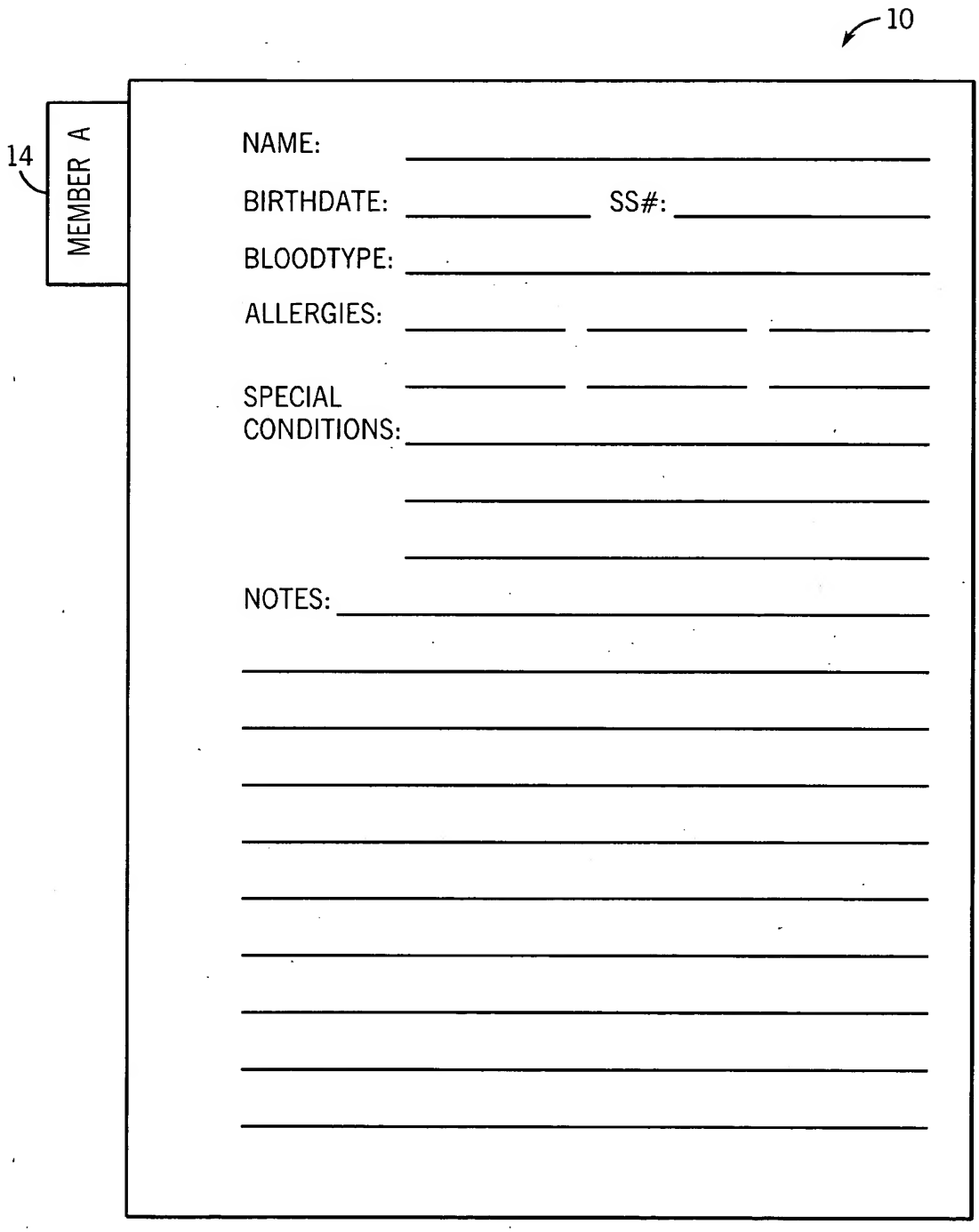
10
14
MEMBER A
NAME:
BIRTHDATE:
SS#:
BLOODTYPE:
ALLERGIES:
SPECIAL
CONDITIONS:
NOTES:

FIG. 2

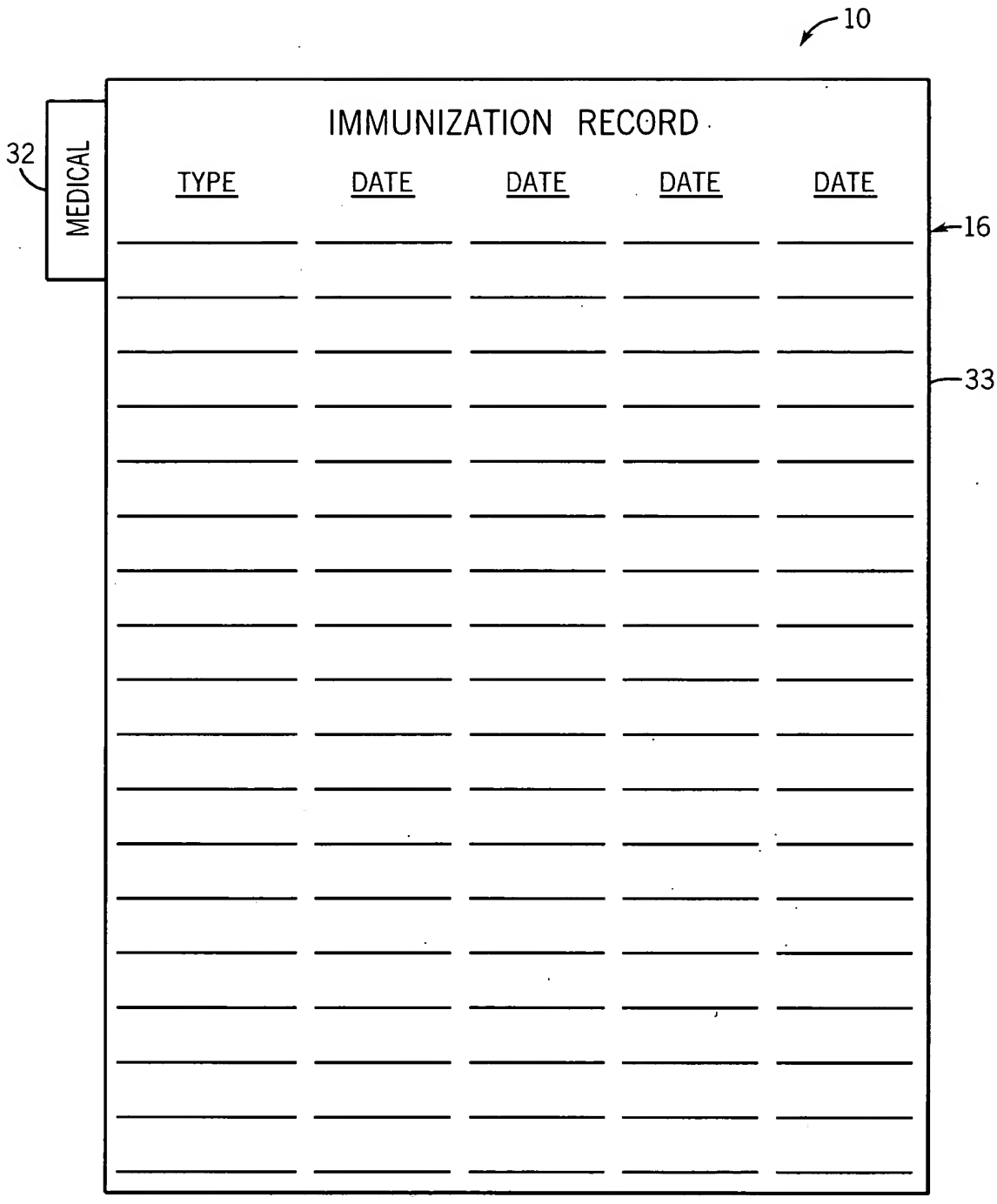
10
IMMUNIZATION RECORD
32
MEDICAL
TYPE
DATE
DATE
DATE
DATE
16
33

FIG. 3

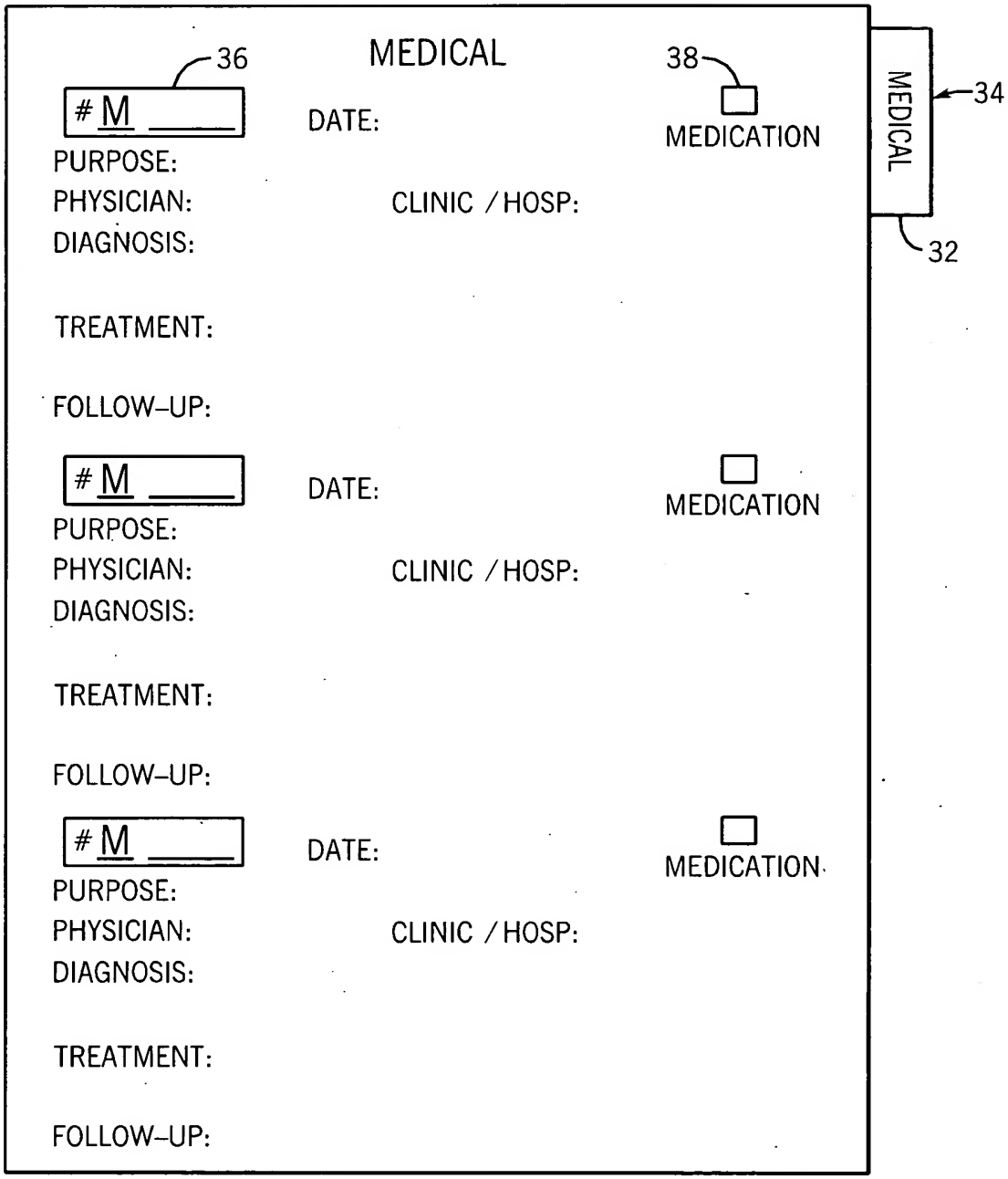
MEDICAL
36
38
MEDICAL
34
32
M
DATE:
MEDICATION
PURPOSE:
PHYSICIAN:
CLINIC / HOSP:
DIAGNOSIS:
TREATMENT:
FOLLOW–UP:
M
DATE:
MEDICATION
PURPOSE:
PHYSICIAN:
CLINIC / HOSP:
DIAGNOSIS:
TREATMENT:
FOLLOW–UP:
M
DATE:
MEDICATION
PURPOSE:
PHYSICIAN:
CLINIC / HOSP:
DIAGNOSIS:
TREATMENT:
FOLLOW–UP:

FIG. 4

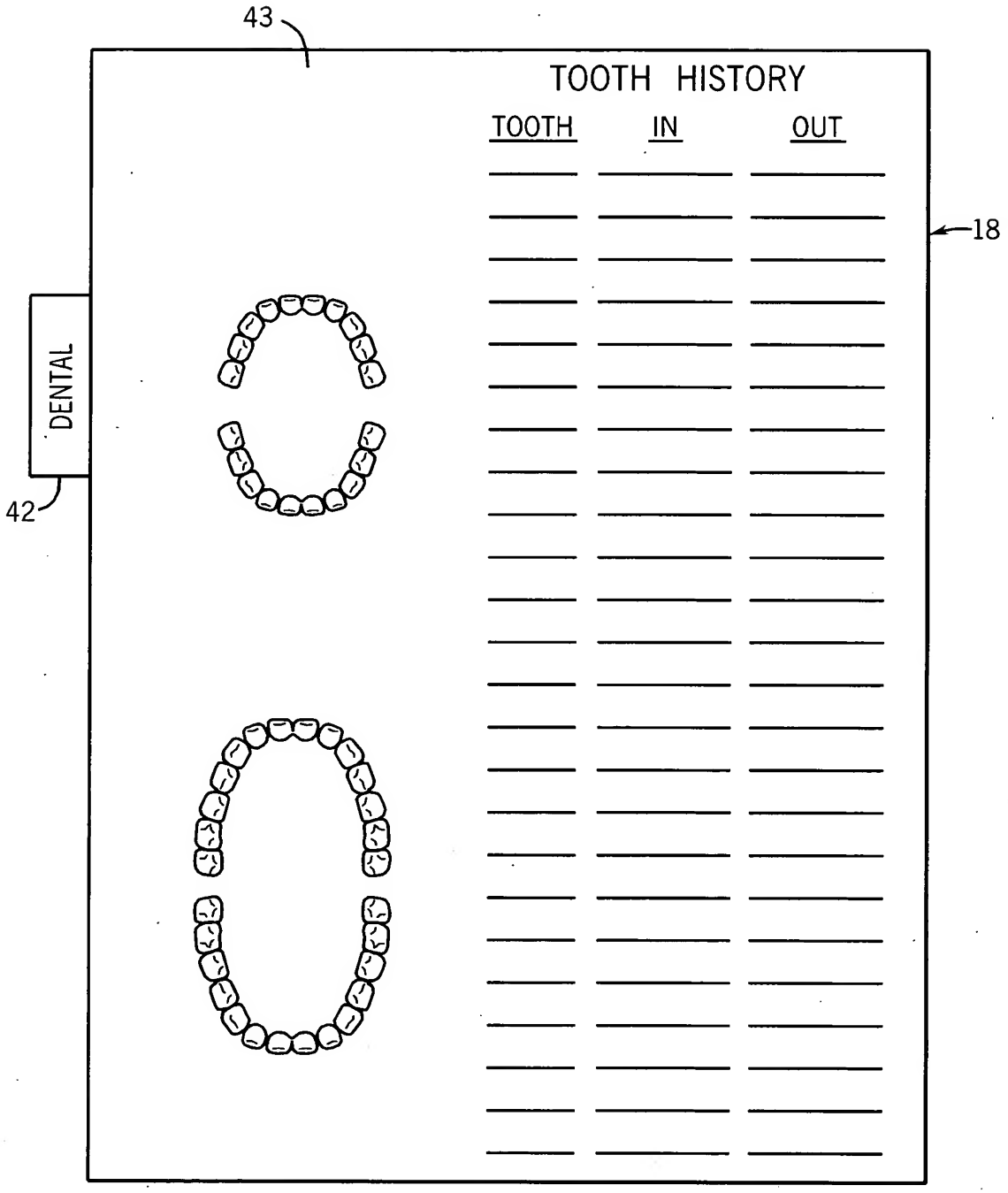

FIG. 5

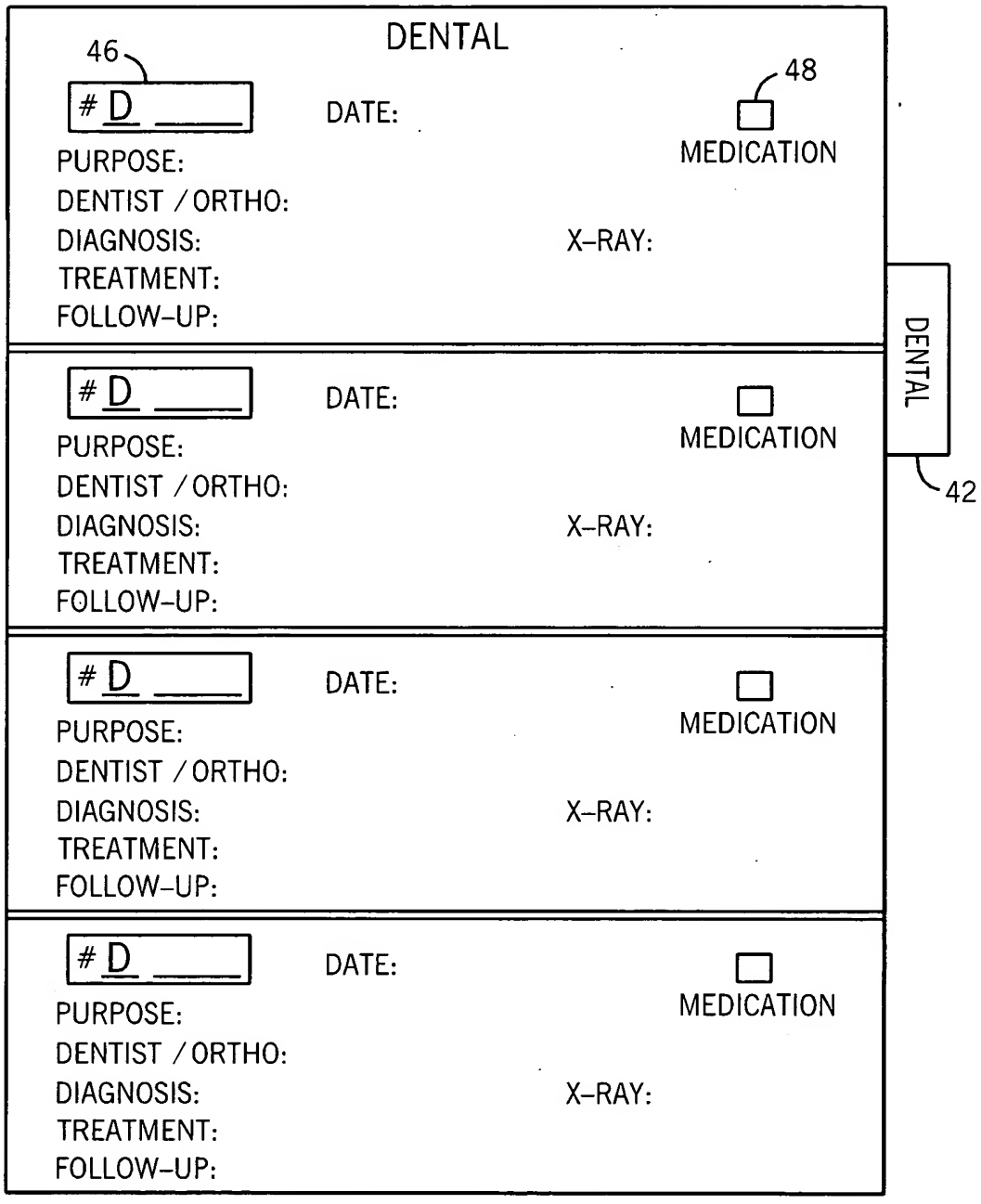
DENTAL
46
D
DATE:
48
MEDICATION
PURPOSE:
DENTIST / ORTHO:
DIAGNOSIS:
X-RAY:
TREATMENT:
FOLLOW-UP:
D
DATE:
MEDICATION
PURPOSE:
DENTIST / ORTHO:
DIAGNOSIS:
X-RAY:
TREATMENT:
FOLLOW-UP:
D
DATE:
MEDICATION
PURPOSE:
DENTIST / ORTHO:
DIAGNOSIS:
X-RAY:
TREATMENT:
FOLLOW-UP:
D
DATE:
MEDICATION
PURPOSE:
DENTIST / ORTHO:
DIAGNOSIS:
X-RAY:
TREATMENT:
FOLLOW-UP:
DENTAL
42

FIG. 6

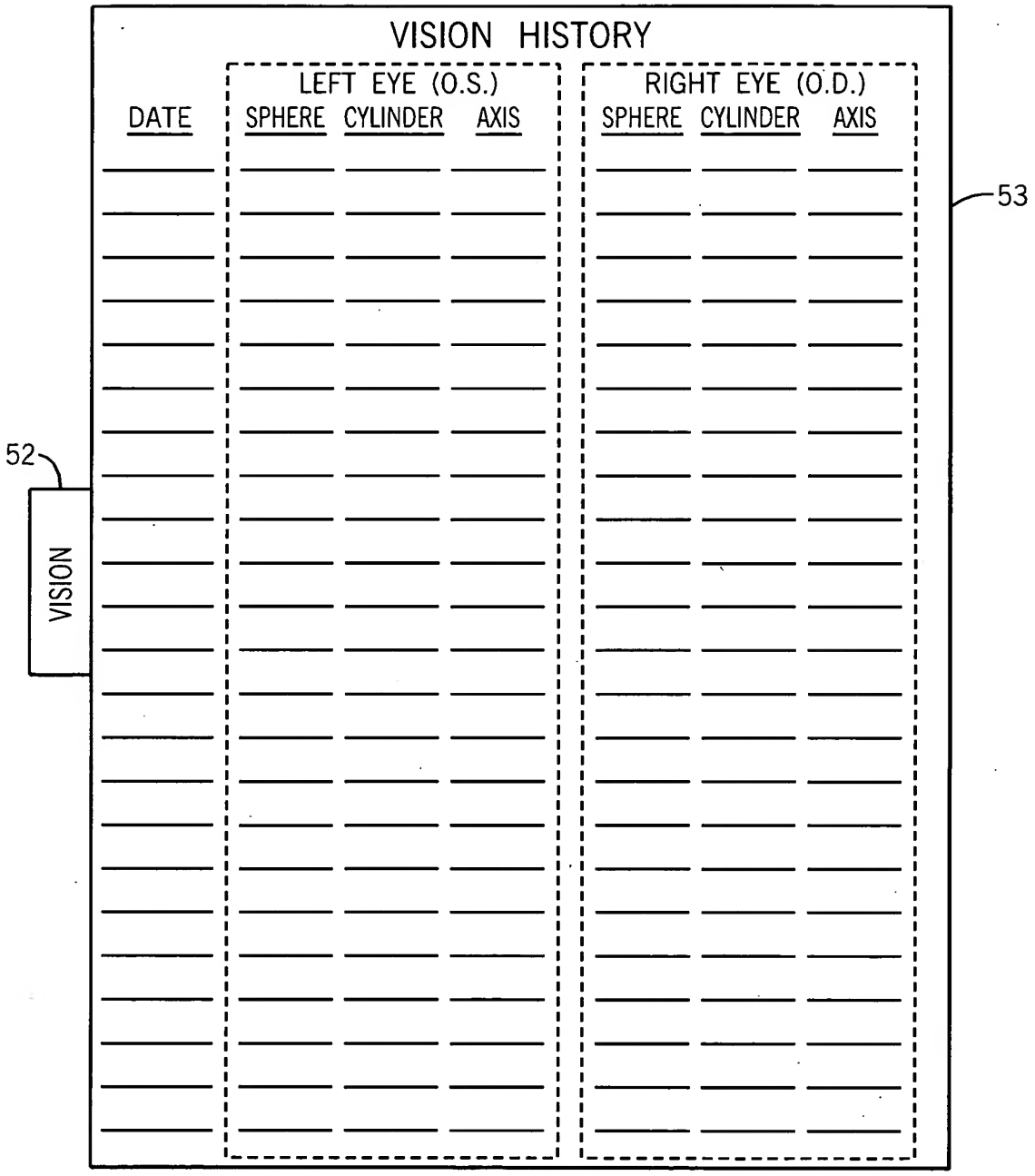
VISION HISTORY
LEFT EYE (O.S.)
RIGHT EYE (O.D.)
DATE
SPHERE
CYLINDER
AXIS
SPHERE
CYLINDER
AXIS
53
52
VISION

FIG. 7

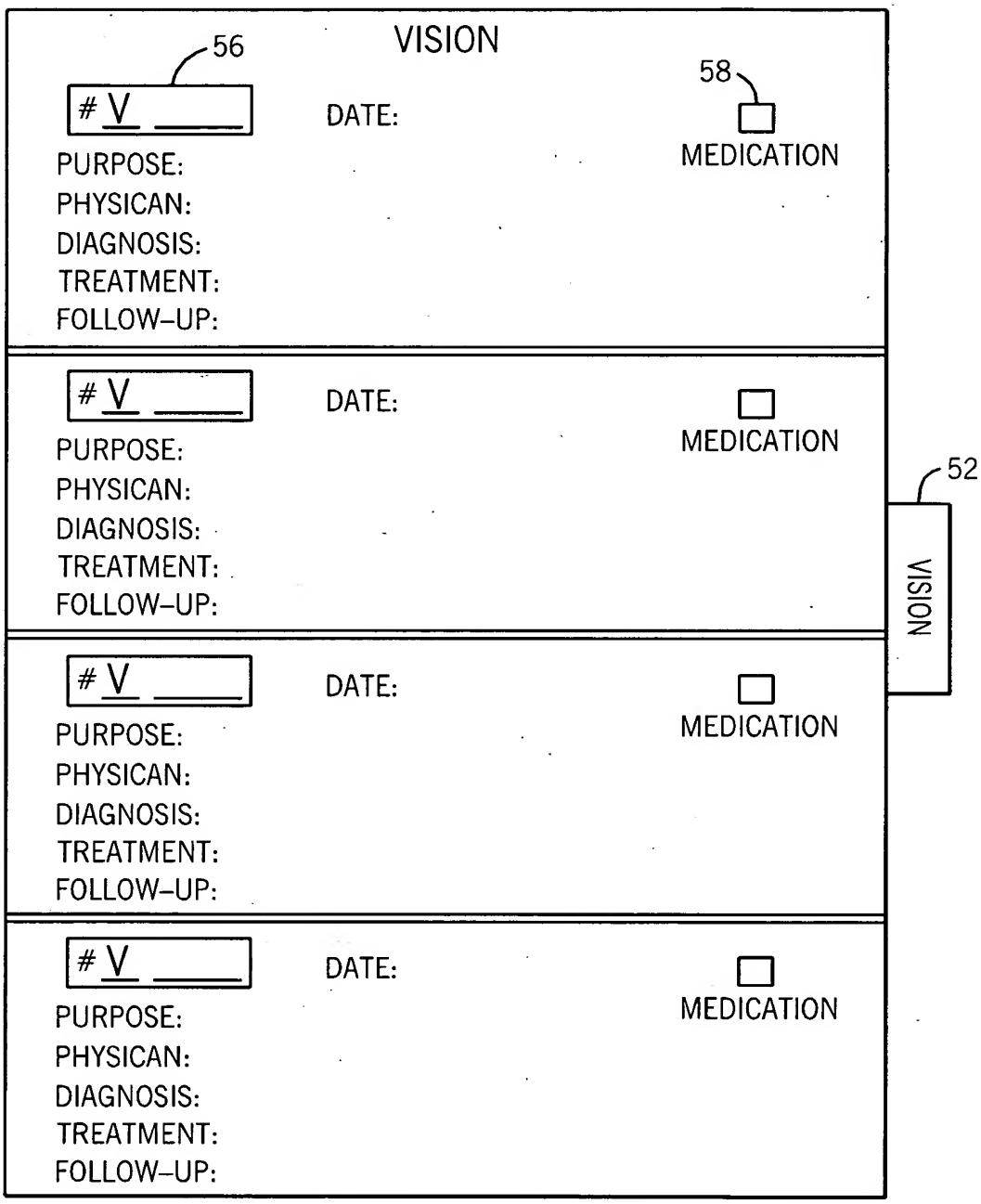
VISION
56
58
V
DATE:
MEDICATION
PURPOSE:
PHYSICAN:
DIAGNOSIS:
TREATMENT:
FOLLOW–UP:
V
DATE:
MEDICATION
PURPOSE:
PHYSICAN:
DIAGNOSIS:
TREATMENT:
FOLLOW–UP:
52
VISION
V
DATE:
MEDICATION
PURPOSE:
PHYSICAN:
DIAGNOSIS:
TREATMENT:
FOLLOW–UP:
V
DATE:
MEDICATION
PURPOSE:
PHYSICAN:
DIAGNOSIS:
TREATMENT:
FOLLOW–UP:

FIG. 8

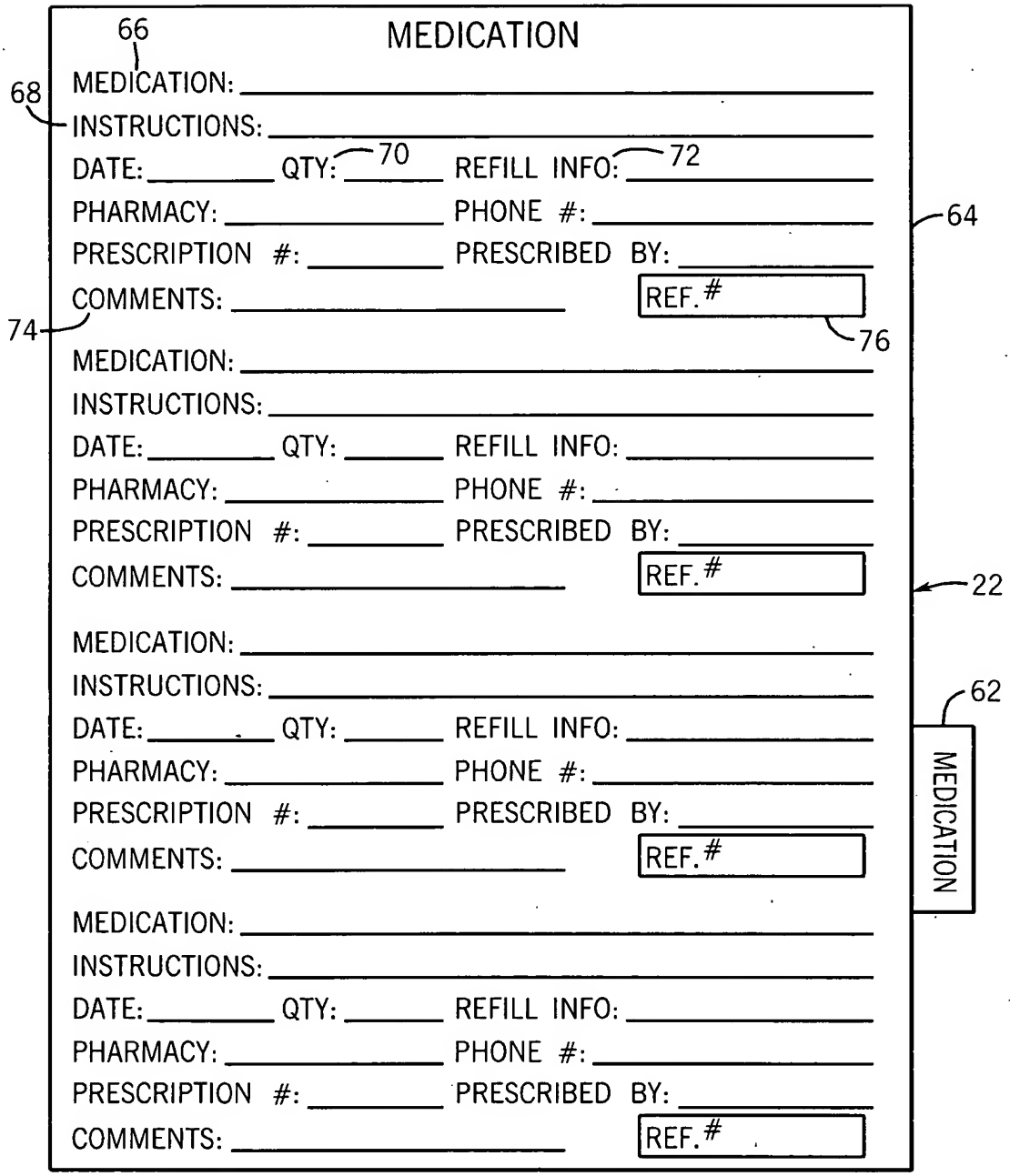
66
MEDICATION
MEDICATION:
68
INSTRUCTIONS:
DATE: QTY: 70 REFILL INFO: 72
PHARMACY: PHONE #:
PRESCRIPTION #: PRESCRIBED BY:
COMMENTS:
REF.#
74
76
64
22
62
MEDICATION

FIG. 9

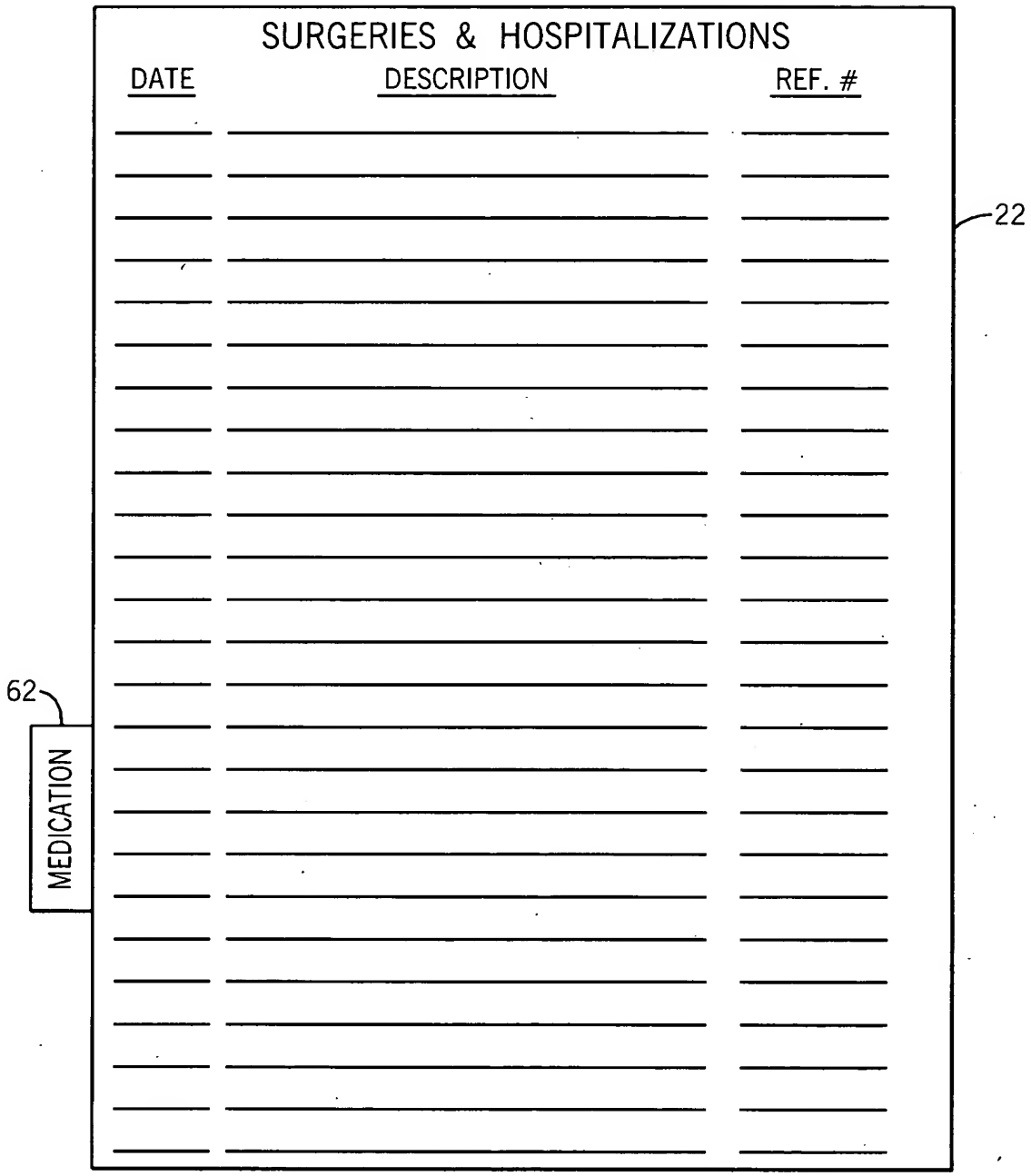
SURGERIES & HOSPITALIZATIONS
DATE
DESCRIPTION
REF. #
22
62
MEDICATION

FIG. 10

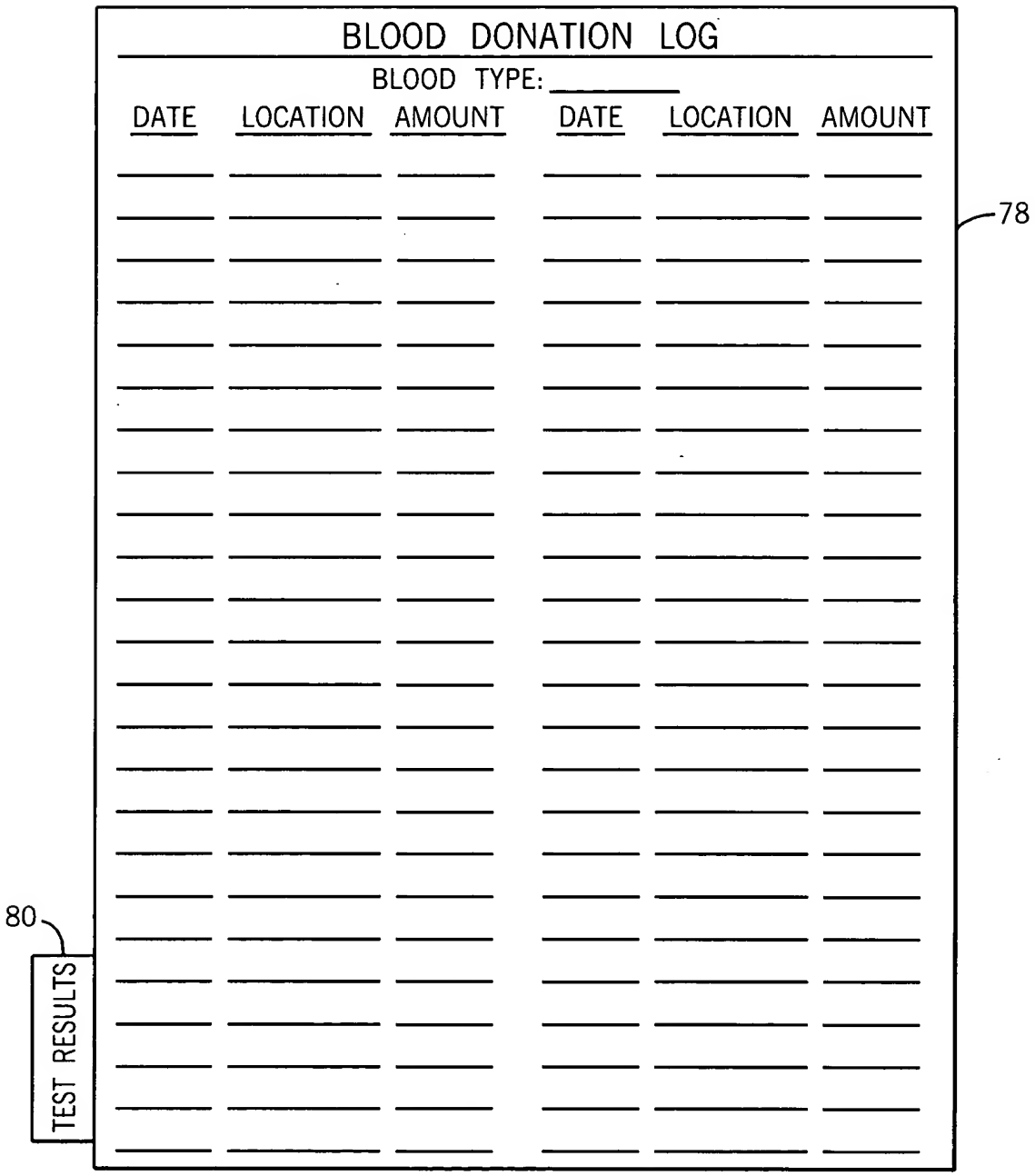
BLOOD DONATION LOG
BLOOD TYPE: _____
DATE
LOCATION
AMOUNT
DATE
LOCATION
AMOUNT
78
80
TEST RESULTS

FIG. 11

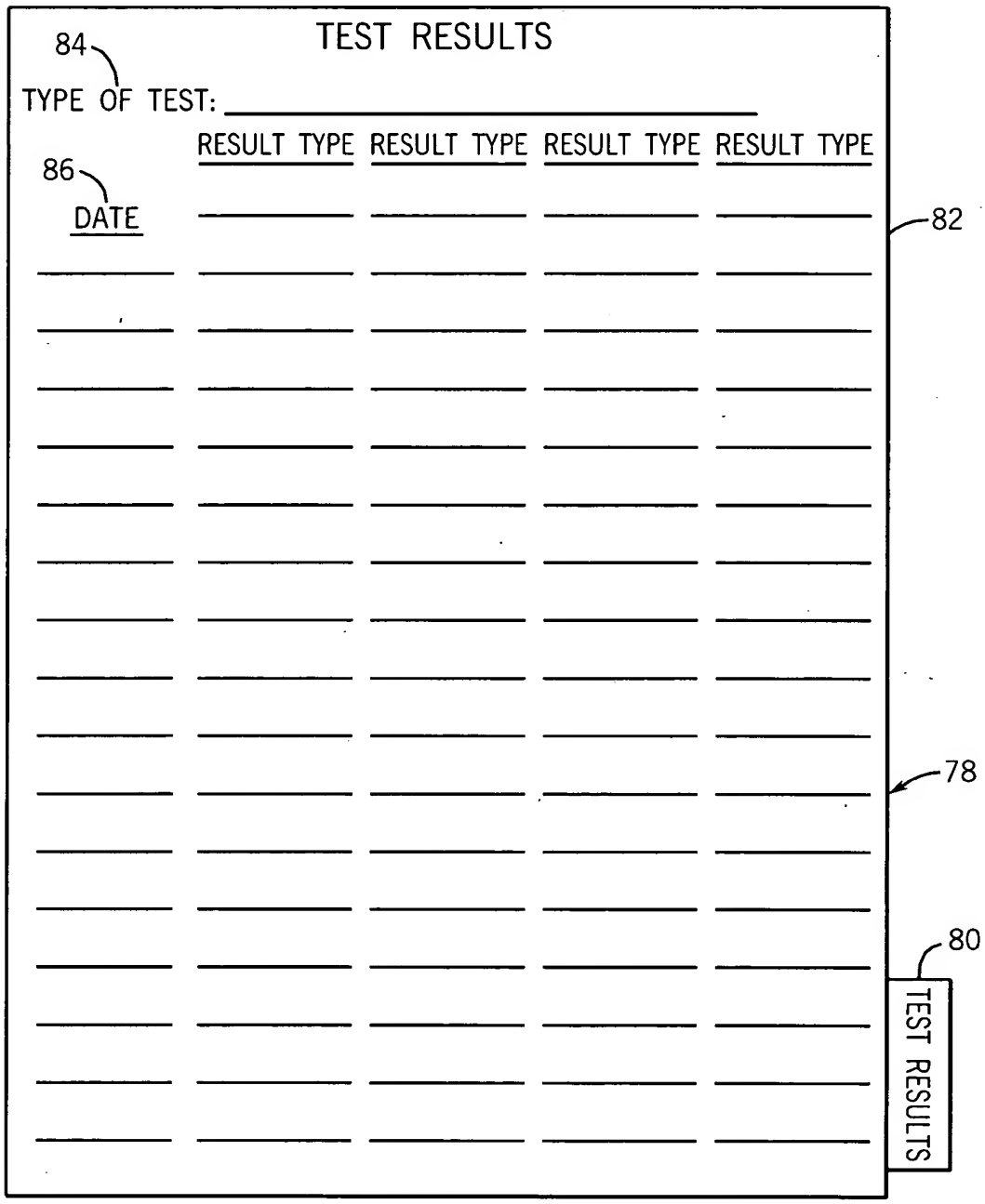
TEST RESULTS
84
TYPE OF TEST:
RESULT TYPE
RESULT TYPE
RESULT TYPE
RESULT TYPE
86
DATE
82
78
80
TEST RESULTS

FIG. 12

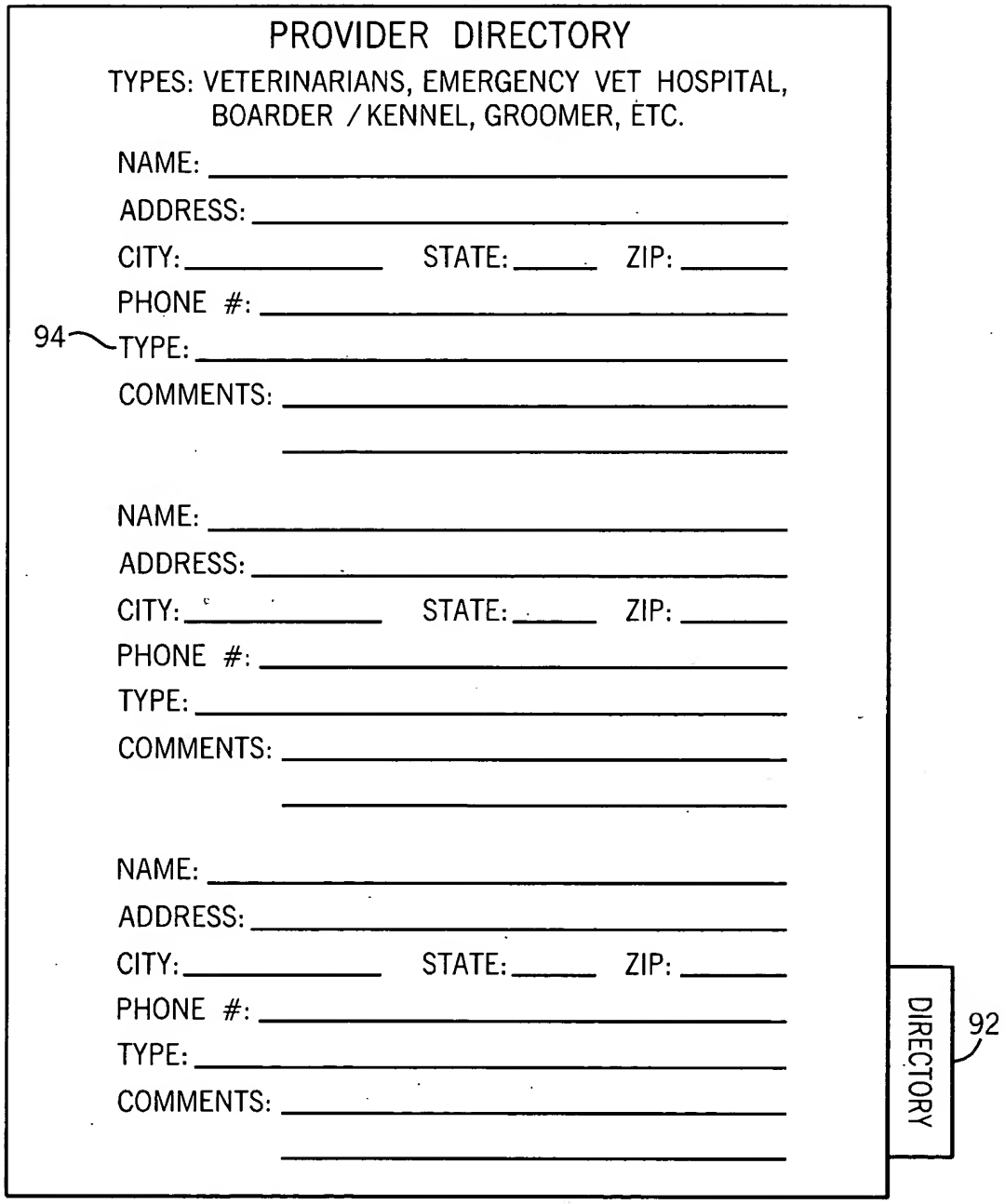
PROVIDER DIRECTORY
TYPES: VETERINARIANS, EMERGENCY VET HOSPITAL, BOARDER / KENNEL, GROOMER, ETC.
NAME:
ADDRESS:
CITY: STATE: ZIP:
PHONE #:
94
TYPE:
COMMENTS:
NAME:
ADDRESS:
CITY: STATE: ZIP:
PHONE #:
TYPE:
COMMENTS:
NAME:
ADDRESS:
CITY: STATE: ZIP:
PHONE #:
TYPE:
COMMENTS:
DIRECTORY
92

FIG. 13